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Dr Khoynezhad. We do the same thing that vascular surgeons and cardiothoracic surgeons around the country, including the ones in Stanford do. It is using abdominal aortic extenders or cuffs. These cuffs have a smaller diameter and are the only ones that are currently available for an 18 to 22-mm aorta. Unfortunately, they are shorter in length and therefore predispose the patient to type III endoleaks. Having said that, we do not have any better options and grafts available at this time.

Dr Miller. Finally, what about chronic dissections? You have shown us some pretty sobering results with (retro-A) dissections, perhaps due to the type of stent graft used, perhaps due to patient selection. Most authorities around the world have abandoned stent grafting for chronic dissection. What is your current posture or Rod White's current posture—both, yours and his, now that you are out on your own? You are in Lincoln now, right?

Dr Khoynezhad. Actually, I work in Omaha. I did my open repair training before my endovascular training, so I do all my chronic dissections open, including thoracoabdominal aneurysms. In terms of selection for chronic type B dissections, the patients had symptoms of malperfusion, including increasing creatinine or potentially increasing bowel ischemia symptoms or abdominal pain. Furthermore, patients with chronically enlarged aneurismal degeneration of chronic type B aortic dissection were included, who were not surgical candidates. A lot of these patients are O_2 dependent with severe chronic obstructive pulmonary disease and were not good candidates for open thoracotomy or thoracoabdominal operations. Those patients at high risk for open repair, who are at high risk for rupture, were offered endovascular repair. I do not agree with the notion that the majority of endovascular centers do not offer endovascular repair for chronic type B aortic dissection. I think in Europe it is much more prevalent than here, as the recent published series suggested. Having said that, the long-term results are not clear, and it has not been studied. For that reason I will not stent chronic dissections in my own personal series.

Notice of Correction

Chang Y-L, Wu C-T, Lee Y-C. Surgical treatment of synchronous multiple primary lung cancers: Experience of 92 patients. *J Thorac Cardiovasc Surg*. 2007;134:630-7.

The authors report two errors in the article: The percentage data were misplaced in the sixth line of the "Results" section of the Abstract and the last line on page 635. The mistakes were the same. They should read as follows: The 5-year survivals were **15.5% and 52.5%** for patients with and without lymph node metastasis, respectively ($P < .001$).

Notice of Correction

Nguyen B-NH, Azimzadeh AM, Zhang T, Wu G, Schuurman H-J, Sachs DH, Ayares D, Allan JS, Pierson III RN. Life-supporting function of genetically modified swine lungs in baboons. *J Thorac Cardiovasc Surg*. 2007;133:1354-63.

The spelling of the last name of Dr. Schuurman was incorrect. The correct spelling is shown in the author line, above.

Notice of Correction

San Juan R, Chaves F, López Gude MJ, Daiz-Pedroche C, Otero J, Cortina Romero JM, Rufilanchas JJ, Aguado JM. *Staphylococcus aureus* posternotomy mediastinitis: Description of two distinct acquisition pathways with different potential preventive approaches. *J Thorac Cardiovasc Surg*. 2007;134:670-6.

The Conclusions section in the abstract in the above-noted article should read as follows:

Endogenous nasal colonization often precedes methicillin-susceptible *S aureus* poststernotomy mediastinitis, which suggests that preoperative decontamination is adequate for preventing methicillin-susceptible *S aureus* poststernotomy mediastinitis, whereas hospital infection control measures seem to be the major factor for preventing exogenous methicillin-resistant *S aureus* poststernotomy mediastinitis.